South East London Integrated Care System

SEL Neighbourhood Working

Theory of Change

PPL

Our Neighbourhood working Theory of Change

South East London Integrated Care System

Introduction

The roll-out of neighbourhood **working reflects an ambitious transformation of our ways of working and operating as a system** - without a clear strategic direction we risk drifting apart in our efforts, and diluting and losing sight of our impact.

We need to **clearly articulate what we will expect to see realised through neighbourhood working**, and a means of understanding if we are on track – this will be captured by a SEL-wide outcomes framework which sets out the scale of the ambition for neighbourhood working beyond our initial priority of implementing Integrated Neighbourhood Teams (INTs), through a clear and succinct set of outcomes across the key domains where we expect to see impact.

Our outcomes must reflect the impact neighbourhood working will have **across the system**, for all partners and residents. **This cannot stop with health;** it must articulate the impact for social care, for wider wellbeing, and life outcomes across our population. It will need to capture the full scope of the ambition reflected by neighbourhood working.

Process

The transition to neighbourhood working constitutes a transformation of our entire system, and the impact of this will appear in complex and interconnected ways.

In order to have confidence our outcomes are connected to inputs and activities which the system is undertaking, and to identify where there are gaps in these activities, the outcomes framework will be developed through a theory of change approach, tracking inputs to outcomes.

A theory of change situates outcomes and activities within their wider context to explain how and why outcomes are be achieved – we believe this approach can hold the complexity of the evolving neighbourhood model and landscape, and maintain a focus on long term, shared outcomes.

Our Neighbourhood working Theory of Change

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This document sets out the theory of change, which was developed through engagement and two focussed workshops with wide system partners over June 2025.

Developing our theory of change provided an opportunity for partners to come together and coalesce around a long-term vision for neighbourhood working.

This document: user guide

The theory of change is structured across four key outcome domains:

- **System resource and sustainability**
- **Workforce impact and staff experience:**
- **Resident experience and community impact**
- **Population Health, Prevention, and Inequalities**

Interwoven across each of these is an emphasis on environmental sustainability. Entries which explicitly relate to the environment are marked with a yellow tree symbol.

Please note: our theory of change is laid out to provide an indication of the logic which connects inputs to activities to outputs to outcomes, however to hold the complexity of benefits realisation from system transformation, it should not be read as a strict logic diagram.

Some entries are duplicated across domains in order to provide a more complete picture of how outcomes will be achieved, and some are deeply connected with other domains within the logic diagram.

This document reflects the first version of our theory of change, and further iterations will be made as we continue to engage and refine our vision for neighbourhood working.

System resource and sustainability

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Outcomes

- The system achieves financial and environmental sustainability and resilience over the long term
- Residents stay well for longer, especially those from disadvantaged communities, with a reduced need for crisis management, and improved prevention and early intervention
- More residents are accessing services locally, in the community

Outputs

- Reduced wastage and duplication of activity between individuals, and within and between organisations
- Environmental sustainability and conscientiousness is embedded in our system-wide culture
- The system has an improved ability and confidence to follow what works, and stop what doesn't
- Community services are better able to identify, care for, and support residents with high and increasing risk of ill health
- There are increases in the delivery of proactive and preventative care and support, including increased partnership and collaboration with the voluntary sector
- Staff across the system have a 'single view' of the resident
- Residents are better able and more confident to manage their own health and wellbeing, and make plans for later in life
- System resource shifts into the community

Activities

- Staff take up environmental training opportunities in sustainability in social care
- System functions are aligned, with staff deployed effectively across organisations
- Population Health Management insights are embedded within planning, delivery, and monitoring and evaluation, supported by a training offer for the workforce
- Resources are flexibly shifted in different ways to address inequalities
- Decisions are made based on need and outcomes, rather than system limitations
- Wider system partners align to and deliver within the neighbourhood model, and are provided with the support and resource to be able to do so effectively
- Genuine co-production and community voice are embedded in decisions to redirect investment to wider services including the VCSE
- Services are designed, commissioned, and effectively evaluated on an outcomes-basis, based on population health needs and aligned to population groups, with commissioning decisions removed from organisational siloes, and an emphasis on reducing wastage
- Shared care plans for the highest acuity/ more complex residents, shared across all system partners
- Community professionals draw specialist input into the delivery of residents' care
- Residents use self-management and education tools to enable them to manage their own health and wellbeing

Inputs

- A cultural emphasis and willingness to focus on long-term (10 years+) transformation and outcomes, and sustainable value
- A single Population Health Management approach, useable analytics tools, and shared data across all system partners
- An effective Integrator in each Place, enabling integration, a "shift left" of resources and the sharing of risk
- Alignment and accountability across the system to a shared outcomes framework, tracked by a single benefits realisation tool with metrics which directly capture impact
- Flexible resourcing mechanisms in place such as pooled funding and integrated workforce models; simplified payment mechanisms, and outcomes-based incentives
- Investment in partnership working for the long-term, and a commitment to genuine collaboration and equal partnership between all partners at every level
- Digital tools that are responsibly designed, interoperable, and future ready - including accessible self-management tools, a single patient record, and AI approaches

Workforce impact and staff experience

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Outcomes

- Staff feel more relevant to and embedded into their communities, and better able to deliver culturally competent care and support.
- Staff feel part of "one team", feel equal with their system counterparts, more supported to do their jobs to the best of their ability
- The system has a resilient and sustainable workforce across all partners, and has an improved ability to attract, recruit, and retain staff

Outputs

- Staff affiliate themselves more with the neighbourhood(s) they support and the area they work in, over their organisations
- A culture of partnership across the system, and increased trust among staff and between organisations to be able to work toward shared outcomes
- Better work/life balance, and less burnt-out or stress among staff
- The thinking space and freedom for staff to respond to resident needs in a genuinely preventative and holistic way, be creative, and deliver an improved and more holistic standard of care to residents, and have the knowledge of local services to be able to do so

Activities

- More staff deliver more care and support in the community
- Staff across the system work closely and collaboratively across providers through a trusted assessor approach, communicating frequently and consistently using one common language, with time to understand shared outcomes, each other's roles and sharing learning
- Unnecessary bureaucracy is reduced, and staff spend more time with residents - applying the skills and expertise they are trained in and best at
- The workforce across the system is flexibly deployed in response to local need
- Staff use accurate and up-to-date information flows to inform service delivery across both planning and the delivery of care and support
- Staff access support and training to make best use of digital tools

Inputs

- Permission for staff to work at the edge of their job descriptions; and the supporting flexible workforce models, integrated tariffs, performance structures, and clinical governance in place to enable this
- Strong, shared, and visible Place-based and neighbourhood leadership, equal across all partners
- Leadership infrastructure in place to facilitate collaborative working, including governance and risk management, shared outcomes, and joint decision making
- Digital tools that are responsibly designed, interoperable, and future ready – including the adoption of a single patient record
- Good career pathways in place, and updated workforce training and a cross-competency framework to support neighbourhood working and good knowledge of services

Resident experience and community impact

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Outcomes

- Residents, particularly those from underserved communities, trust, and feel valued and understood by their services and the professionals they interact with, and know that their input has a direct impact on their care and wider services
- Residents and carers have improved confidence managing their health and wellbeing through accessing the right services, and have reduced anxiety around their needs
- Communities are supported to thrive as local services are improved, more residents are supported to become or remain economically active and in employment, and environmental quality is improved

Outputs

- Residents only tell their story once and experience continuity of care with every contact
- Residents are treated as whole people, and families are treated as whole families, and are supported with holistic care at every point of access which takes into complete account their psycho-social context
- Residents receive the right level of information and communication to better understand the support available to them
- Residents, especially those in greatest need, experience shorter waiting time to access the right care, support, or treatment (including specialist treatment)
- Residents access the right care and support first time
- Residents are able to take greater ownership of their health and wellbeing, understand their own pathway, and proactively self-manage
- Services are rooted in the community, better designed to meet the needs of residents and communities as they experience them, and more often benefit from community-sourced innovation
- Community and town centres are invigorated, with improved spaces for community collaboration, connection, and action

Activities

- Staff exercise increased understanding, knowledge, and respect among the workforce for the different communities they serve
- Staff work in a highly collaborative and communicative way across organisations to deliver care to residents, moving away from referrals in favour of human-human communication
- Staff co-produce care plans with residents
- Community-based professionals draw upon specialist input as needed to deliver holistic care to residents locally
- Technology and data-sharing are used and deployed responsibly
- Staff and services speak in a common language, and provide coordinated and consistent support to residents and communities to understand and interact with new ways of delivering services, including self-managing their health and support needs
- Services are always co-designed with the residents and communities - without outward organisational affiliations, accessible in the places where residents are in the community that feel safe (including online and in physical hubs)
- Existing community organisations and hubs which serve all population groups, especially underserved groups, are active in delivering and shaping local services
- There is greater grassroots action and community activation around the intersection of the environment and health and wellbeing outcomes

Inputs

- Reduced multiple points of access
- An outcomes, resident-centred culture, where staff are always supported to act in the interests of residents and communities over organisational interests
- Commitment to genuine collaboration and equal partnership working between all partners at every level including community partners, VCSE partners, and partners working within the wider determinants
- Easy to use tools and improved information available to residents, in formats accessible to all, to help them to manage their own health and wellbeing needs
- Neighbourhood footprints which resonate with communities
- Resident, community, and grassroots voices embedded in neighbourhood design and governance with consistent renumeration
- A cultural commitment to fostering healthy environments
- Investment in community infrastructure (including training, environment and estates, and digital) and the VCSE sector to support full participation in the neighbourhood model

Population Health, Prevention, and Inequalities

South East London Integrated Care System

Outcomes

- Inequalities in psycho-social and physical and mental health outcomes experienced by disadvantaged groups are reduced, meaning more residents and carers stay well, independent, and in the community for longer; and eventually experience a good death
- Fewer residents reach a crisis point in their health or wider wellbeing, and are able to stay well for longer
- Community and resident quality of life is improved, in the ways which matter to residents

Outputs

- Improved and earlier identification of patients with unmet needs, escalating risk, or complexities, and fewer preventable issues are medicalised
- The need for more intensive forms of social care support is prevented and delayed
- Residents and communities access the support they need locally within their neighbourhoods
- Resources are more equitably distributed to support underserved communities
- Residents are better able to manage their own health and wellbeing and plan for later life
- Services are locally tailored to meet local population health needs

Activities

- Up-to-date and reliable patient data is maintained across the system including social and demographic data
- Resources are flexibly shifted in different ways to address inequalities
- Transparent, accessible, consistent, and relevant messaging for communications and engagement with residents around accessing and shaping services locally
- Services are commissioned based on outcomes and population health needs, supported by integrated commissioning
- All partners are active within INTs, including LAs and VCSE, such that residents are able to access preventative support across a broadened set of services and settings (including schools, libraries, and barber shops)
- Active travel schemes are in place to support residents to access services
- Population Health Management analytics and modelling are applied by neighbourhoods and Places to both planning and care delivery: to tailor resourcing and interventions, and to systematically and proactively flag and identify individuals vulnerable to health and social inequalities, rising risk, or the effects of climate change

Inputs

- Clear roles and responsibilities, and the right resource in place with respect to proactive case management
- Professional and organisational responsibility for population outcomes, rather than for separate caseloads
- Strong leadership which promotes the proactive and equal involvement of all system partners in the planning and delivery of neighbourhoods, and clear shared systems of governance, risk, and accountability to support this
- A consistent Population Health Management and risk stratification approach, and user-friendly Population Health Management tools which support all user groups (including commissioners & planners, clinicians, care givers, and VCSE partners
- A clear vision from leadership for neighbourhood working, for both the short and the long-term
- Codesign and community and grassroots voices embedded within decision making across the system, with consistent renumeration
- A shared view of population and patient needs through integrated data and effective information sharing across sectors
- Embedded approaches to services relating to the wider determinants (such as housing)
- Accessible estates, especially for underserved communities
- Digital tools that promote self-management among residents, with access to personal data